

Choice in Family Care

Family Care has frequently been described as increasing the choices available to consumers. At the same time, Family Care limits choice – through its defined provider network, and because the CMO must provide services and supports as cost-effectively as possible. This seeming conflict in what Family Care tries to achieve – both to increase and to limit choice – has been difficult for care managers, providers, consumers and state staff to understand and operationalize. These stakeholders have identified the need for a document that clearly describes what “choice” means in Family Care. This is that document.

There are several principles which work together to form the overall philosophy of Choice in Family Care. There is no rule or formula for how these different principles work together in each situation, because each member and situation is different and unique. Understanding these principles will hopefully help you understand better what “choice” means in the Family Care program.

Entitlement: The Family Care benefit package is available to all eligible people in the service areas in which it exists, and people do not have to wait until funding is available to receive services. Eligible people also have a choice of receiving services under the Medicaid fee-for-service system, but that does not provide all the long-term care services available in Family Care.

Service Flexibility. The Family Care benefit is flexible in that it allows interdisciplinary teams to authorize alternative services and supports that will be most effective and cost-effective, even if they are not included in the defined benefit package. In Family Care, interdisciplinary teams authorize those services that best meet the needs of the consumer in the least costly manner, and that are not covered by other insurance policies or payment sources. For example, having both supportive home care and personal care in the Family Care benefit allows care managers to be flexible and use supportive home care instead of the more expensive personal care benefit for most direct care needs.

Personal outcomes. Family Care uses an individualized, person-centered process to identify the member’s personal outcomes and preferences. One way Family Care measures the quality of the services and supports provided is by how effective they are in supporting the member’s personal outcomes. Family Care may not be able to help the member get all the results he wants out of life – some outcomes might be outside the realm of what health and long-term care supports can achieve, or the cost of fully achieving an outcome might mean that the member has to compromise on what can be provided.

Cost-effectiveness. In order to assure services are available to all who need them, everyone involved in Family Care must work to assure those services are as cost-effective as possible. This includes enrollees and their families and representatives. Members do not have the right or ability to choose whatever services they want; rather, they have the right and responsibility to choose among the cost-effective options the

CMO makes available to them. Being cost-effective means the least costly options that are effective in supporting the member's outcomes.

The care management team. The care management team (also called the interdisciplinary team or IDT) consists of the member and the CMO nurse and social worker/care manager. The team members work together to identify the enrollee's outcomes and find the most cost-effective ways to support those outcomes. This takes a lot of communication, negotiation and even compromise. Both the CMO staff and member have responsibility to fully engage in this process – the member is not just a passive recipient of services, but a partner in finding the most effective and cost-effective ways to get the results he or she wants from Family Care services.

Choice of residential setting. One of the most meaningful ways Family Care gives people choices is that members do not need to wait for community-based services. Where the entitlement to Family Care isn't available, people may be on a waiting list for services in their own home or in a community-based congregate living situation.

There is a strong emphasis in Family Care on people being able to live in the setting of their choice, and especially on being able to live in non-institutional settings if that is their preference. The CMO, however, still has a responsibility to find the most cost-effective options to accomplish that. In many instances, the member living in his or her own home will be the most economical option. However, that may not always be the case. For example, there may be times when the cost of necessary modifications to a member's own home is not reasonable, compared to the cost of living in an apartment or alternate community-based residential setting. The CMO should strive to offer people ways to live in the settings of their choice, and in non-institutional settings if that is their preference, and it should work to assure the options it can offer are as cost-effective as possible.

Choice of Care, Supports, and Services. Once the member has decided what outcomes he or she wants to work toward, the member and the CMO interdisciplinary care management team decide what services or supports are most cost-effective in achieving those outcomes. The CMO will hopefully be able to offer more than one choice of service to meet the member's outcomes, but that may not always be possible. The CMO's responsibility is to offer the most cost-effective way – balancing cost and choice – to support the member's outcomes.

Choice of Providers. For providers who come into the member's home or provide intimate personal care, the CMO must purchase services from whoever the member chooses as long as that person meets the CMO's requirements and accepts the CMO's rates.

For other services, the member can choose among the providers in the CMO's provider network. However, the CMO may be able to have a more cost-effective arrangement with one provider than another; in this case, the CMO can offer the most cost-effective way to provide the necessary supports. For example, a CMO might have an arrangement with

one supportive home care provider for a daily or overnight rate for services, and only contract for hourly services with another supportive home care provider. The daily rate is almost always more economical, and the CMO can limit choice to the most cost-effective way to provide the needed support.

Members can request a provider who is not in the provider network and the CMO must consider the request. Instances where a member's request for a provider outside the network should be honored by the CMO include when network providers: a) do not have the capacity or specialized expertise to meet the need; b) cannot meet the need on a timely basis; or c) are located in geographic locations or buildings that make transportation or physical access an undue hardship to the member.

Self-Directed Supports. Members can choose to self-direct all or some of their services.

- If members choose this option, the CMO will make resources, including a budget, available to the member based on what it would have spent if it managed those services. The member can then use that budget amount to buy specific services to meet their needs.
- The CMO can limit the services that a member can self-direct. For instance, this option is not available for residential living arrangements.
- The CMO may put limits on the self-directed option if members are not staying within their budget, if they have used resources illegally or in a way that is too risky to health and safety, or if someone else is making decisions for the member that are not based on what the member wants.

Health and safety: The CMO cannot provide goods or services that are dangerous or illegal. While the CMO cannot stop members from making some unhealthy or risky choices (such as smoking or engaging in a dangerous hobby), the CMO needs to carry out its own responsibilities and obligations to protect – or at least not endanger – members' health and safety. The CMO will not provide supports for unnecessarily unhealthy or risky choices.

Appeals. Even though the member is part of the care management team, there will be times in a managed care program when the CMO and member will not agree on what supports are reasonable or necessary. The member can then appeal the CMO's decision, to the CMO itself, or to the state.